

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
00497						02053					
1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Calvert</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lance Frederick</u>				c. LENGTH OF STAY IN 1b <u>2 1/2 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Island Creek</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Calvert County Hospital</u>						d. STREET ADDRESS —					
3. NAME OF DECEASED (Type or print) <u>Brooke</u>			First Middle Last <u>Bond</u>			4. DATE OF DEATH <u>Jan. 29 1966</u>			Month Day Year		
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 5, 1875</u>		9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer - Merchant</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Calvert County, Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Brooke Bond</u>						14. MOTHER'S MAIDEN NAME <u>Eliza Tenque</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>219-32-2048</u>		17. INFORMANT <u>Catherine Hance, Island Creek, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery sclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 29, 1966</u> to <u>Jan 29, 1966</u> , that (I) (we) last saw the deceased alive on <u>Jan 29, 1966</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>[Signature]</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D. 22d. ADDRESS <u>St. Thomas</u>			22b. DATE SIGNED <u>1/30/66</u>		
22c. PHYSICIAN'S NAME (Type) <u>R. DEVIHARRREAL</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 3, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Christ Church Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Port Republic, Calvert, Md.</u>					
24. FUNERAL DIRECTOR <u>A.A. Harkness Son</u>						ADDRESS <u>Box 34, Port Republic, Md.</u>		25a. REC'D BY REGISTRAR <u>FEB 8 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00498				CERTIFICATE OF DEATH				00489			
1. PLACE OF DEATH a. COUNTY Calvert b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings c. LENGTH OF STAY IN 1b 1 year d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Padgett's Nursing Home						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Huntingtown d. STREET ADDRESS 04-1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) MARY			First REBECCA			Middle BOWEN			Last		
5. SEX Female			6. COLOR OR RACE White			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH June 7, 1877		
9. AGE (In years last birthday) 88 yrs.			IF UNDER 1 YEAR Months			IF UNDER 24 HRS. Days			Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife						10b. KIND OF BUSINESS OR INDUSTRY Domestic			11. BIRTHPLACE (County & State, or foreign country) Calvert Co., Maryland		
12. CITIZEN OF WHAT COUNTRY? USA											
13. FATHER'S NAME James Hance						14. MOTHER'S MAIDEN NAME Mary Denton					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16. SOCIAL SECURITY NO. 217-48-9465			17. INFORMANT J. Kenneth Bowen, Huntingtown, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 794x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) old age. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 1963 , 19, to Jan 22 , 19 66 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 9:30 M, from the causes and on the date stated above.											
22a. SIGNATURE Issam F. Damalouji						22b. DATE SIGNED 1/24/66					
22c. PHYSICIAN'S NAME (Type) Issam F. Damalouji						22d. ADDRESS PRINCE FREDERICK, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Jan. 25, 1966		23c. NAME OF CEMETERY OR CREMATORY Emmanuel Meth. Chr. Cemetery Plum Point, Md.				23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR Hitchman Funeral Home						ADDRESS Owings, Maryland			25a. REC'D BY REGISTRAR Jan 28 1966		
									25b. REGISTRAR'S SIGNATURE Charles Judge		

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FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00490

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill page 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived, if institutional residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Calvert</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ches Beach</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ches Beach</i>	
c. LENGTH OF STAY IN 1b <i>04-1</i>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Calvert Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Wanda</i> Middle <i>Floretta</i> Last <i>Chase</i>		4. DATE OF DEATH Month <i>1</i> Day <i>1</i> Year <i>1966</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 26, 1965</i>
9. AGE (In years last birthday) <i>1</i> yrs.		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTH PLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MARRIED NAME <i>Dorothy Harris</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Malnutrition</i> 7720 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>This body skin & bone</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>10:30</i> p.m. <i>11</i> 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>H W Ward</i>		22. DATE SIGNED <i>11/1/66</i>	
EXAMINER'S NAME (Type)		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>1-3-66</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Plum Point Church</i>	23d. LOCATION (City, town or county) (State) <i>Huntington, Md.</i>
24. FUNERAL DIRECTOR <i>Leroy E. Berry</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	
25b. REGISTRAR'S SIGNATURE		DATE <i>JAN 5 1966</i>	

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Serial 1-3-66
Lt Col
Huntington
Blum Point Camp
Huntington, W. Va.

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VR A15 (4)
ISM 7/61

00500

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00491

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Calvert			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Huntingtown				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Huntingtown 04-1			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) _____				d. STREET ADDRESS _____			
3. NAME OF DECEASED (Type or print) First Middle Last Ridgley Clayton Cox				4. DATE OF DEATH Month Day Year Jan. 26 19 66			
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 7 1898		9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY States Roads		11. BIRTHPLACE (County & State, or foreign country) Calvert County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel C. Cox			14. MOTHER'S MAIDEN NAME Adele Grierson				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. ?		17. INFORMANT Address Mrs. Louise G. Cox, Huntingtown Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive C.V.D. disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH _____	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) (County) (State) _____	
21. I certify that (I) (this hospital) attended the deceased from 7/10 1965 to 1/26 1966 , that (I) (we) last saw the deceased alive on 1/25 1966 , and that death occurred at 8 P.M. from the causes and on the date stated above.							
22a. SIGNATURE G. J. Weems				22b. ADDRESS Huntingtown, Md.		22c. DATE SIGNED 1/27/66	
22c. PHYSICIAN'S NAME (Type) G. J. Weems, M. D.				22d. ADDRESS Huntingtown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 29, 1966		23c. NAME OF CEMETERY OR CREMATORY Miranda Cemetery		23d. LOCATION (City, town or county) (State) Huntingtown Calvert Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE A.A. Hankness, Jr.				25a. REC'D BY REGISTRAR FEB 1 1966		25b. REGISTRAR'S SIGNATURE [Signature]	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00501

CERTIFICATE OF DEATH

00492

<p>1. PLACE OF DEATH a. COUNTY Calvert b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural-Prince Frederick c. LENGTH OF STAY IN ID 3 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital</p>				<p>2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Huntingtown, rural d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>															
<p>3. NAME OF DECEASED (Type or print) First Samuel Middle Hezekiah Last Dixon</p>		<p>4. DATE OF DEATH Month January Day 9 Year 1966</p>		<p>5. SEX male</p>		<p>6. COLOR OR RACE Caucasian</p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/></p>		<p>8. DATE OF BIRTH 4/10/97</p>		<p>9. AGE (In years last birthday) 68 yrs.</p>		<p>IF UNDER 1 YEAR Months Days Hours Min.</p>		<p>IF UNDER 24 HRS. Hours Min.</p>			
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter</p>				<p>10b. KIND OF BUSINESS OR INDUSTRY Construction</p>				<p>11. BIRTHPLACE (County & State, or foreign country) Calvert-Maryland</p>				<p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>							
<p>13. FATHER'S NAME Joseph A. Dixon</p>						<p>14. MOTHER'S MAIDEN NAME Hester Cox</p>													
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)</p>				<p>16. SOCIAL SECURITY NO. 217-12-9038</p>				<p>17. INFORMANT Mason Dixon Address Huntingtown, Maryland</p>											
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Heart Failure DUE TO (c)</p>														<p>INTERVAL BETWEEN ONSET AND DEATH</p>					
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>														<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></p>					
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>															
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19</p>				<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>				<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>				<p>20f. (City or town) (County) (State)</p>							
<p>21. I certify that (I) (this hospital) attended the deceased from January 6, 1966 to Jan. 9, 1966, that (I) (we) last saw the deceased alive on January 9 1966, and that death occurred at 11:15 pm from the causes and on the date stated above.</p>																			
<p>22a. SIGNATURE [Signature]</p>												<p>22b. DATE SIGNED 1/10/66</p>							
<p>22c. PHYSICIAN'S NAME (Type) Issam F. El-Damalouji, M.D.</p>												<p>22d. ADDRESS Prince Frederick, Maryland</p>							
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) Burial</p>				<p>23b. DATE THEREOF Jan. 12, 1966</p>				<p>23c. NAME OF CEMETERY OR CREMATORY Emmanuel Church Cemetery</p>				<p>23d. LOCATION (City, town or county) (State) Plum Point, Cal. Co. Md.</p>							
<p>24. FUNERAL DIRECTOR Hutchins Funeral Home Owings, Md ADDRESS</p>												<p>25a. REC'D BY REGISTRAR Charles Judge DATE JAN 14 1966</p>				<p>25b. REGISTRAR'S SIGNATURE</p>			

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00502					00493						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)						
a. COUNTY <u>Calvert</u> MARYLAND					a. STATE <u>MD.</u> b. COUNTY <u>Calvert</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PR. Fred.</u>				c. LENGTH OF STAY IN 1b <u>7 yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North Beach, MD.</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Calvert Nursing Home</u>					d. STREET ADDRESS <u>403-5th St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)			First		Middle		Last		4. DATE OF DEATH		
			<u>MINNIETTA</u>		<u>C.</u>		<u>DYER</u>		Month <u>JAN</u> Day <u>22</u> Year <u>1966</u>		
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) <u>97</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Joseph Hood</u>					14. MOTHER'S MAIDEN NAME <u>Unknown</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Effie K. Boomer</u>				
					Address <u>Hyattsville, Md.</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Upper Resp. Infection</u> <u>434.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac Decompensation</u> DUE TO (c) <u> </u>										INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Dec.</u> , 19 <u>38</u> , to <u>JAN.</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>JAN. 21</u> , 19 <u>66</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Page C. Jett</u>										22b. DATE SIGNED <u>JAN. 22, 1966</u>	
22a. PHYSICIAN'S NAME (Type) <u>PAGE C JETT</u>					22d. ADDRESS <u>PRINCE FREDERICK</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>1-24-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Washington Natl Cem. Suitland, Md.</u>			23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR <u>W.W. Chambers Co., 51711th St.</u>					25a. REC'D BY REGISTRAR <u>JAN 26 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

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Atlantic 1913. The. Mrs. A. A. Ward, Atlantic 1913.

EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO DEPUTY MEDICAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00504

00495

1. PLACE OF DEATH a. COUNTY <u>Calvert</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Fairfax</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St Leonard</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St Leonard</u>	
c. LENGTH OF STAY IN <u>10 Wm</u>		d. STREET ADDRESS <u>8408 Dorsley Ave</u>	
e. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Calvert Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Lukens Flood</u>	First <u>John</u> Middle <u>Lukens</u> Last <u>Flood</u>	4. DATE OF DEATH Month <u>1</u> Day <u>1</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/8/18</u>
9. AGE (In years last birthday) <u>47</u> yrs		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Leb Co</u>	
11. BIRTH PLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>J. Flood</u>		14. MOTHER'S MAIDEN NAME <u>Artie Foster</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>141-01-2628</u>	
17. INFORMANT <u>Wm. Demaine</u>		Address <u>St Leonard Calvert Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> 7824 DUE TO (b) <u>7824</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>7824</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Came to Ches. Club for day but died in 10 min.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Ches. Club</u>	
20c. TIME OF INJURY Month, Day, Year <u>2</u> Hour <u>11</u> p.m. <u>11</u>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Ches. Club</u>	20f. (Only on town) (County) (State) <u>St Leonard Calvert Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>H W Ward</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H W Ward</u>		M.O. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Calvert B. Ward</u>	
22. DATE SIGNED <u>1/5/1966</u>		Address (Street, city, town, or county) <u>St Leonard Calvert Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1/5/1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Fort Myer, Virginia</u>
24. FUNERAL DIRECTOR <u>Wm. Demaine & Son Funeral Home</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
Address <u>Alexandria, Virginia</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
00505					00496							
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)							
a. COUNTY			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
Calvert			Lusby-Md.		Lusby -Md.		04 - 1					
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH		5. AGE (In years last birthday)			6. IS UNDER 1 YEAR		
Charlotte A Foote					1 19 1966		74 yrs.			Months Days Hours Min.		
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. IF UNDER 24 HRS.		
F		C		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Jan. 13-		74 yrs.		Months Days Hours Min.		
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?			
Domestic						Maryland						
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME							
Benjamin Bishop					Elizabeth Taylor							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT							
(If yes give war or dates of service)					Archie Foote Lusby, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]										INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) Myocardial infarction												
4201 DUE TO												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
(b) Atherosclerosis												
DUE TO												
(c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)		
Hour a.m. p.m.		19		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>								
21. I certify that (I) (this hospital) attended the deceased from 2/10/66, to 2/19/66, that (I) (we) last saw the deceased alive on 1/19 1966 and that death occurred at 4 PM, from the causes and on the date stated above.												
22a. SIGNATURE						M.D. ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS				1/19/66		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county)			(State)	
			1-23-66		St. John Church Cem.			Lusby Maryland.				
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
P. E. Sewell						JAN 24 1966		J. Charles Judge				
Prince Frederick-Md.												

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John F. Kennedy
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH																													
1. PLACE OF DEATH a. COUNTY Calvert b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jewell-Dunkirk d. STREET ADDRESS — e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																								
3. NAME OF DECEASED (Type or print) Willis Atwood Fowler			4. DATE OF DEATH 1 4 1966		5. SEX M					6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/27/90		9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer					10b. KIND OF BUSINESS OR INDUSTRY Farming					11. BIRTHPLACE (County & State, or foreign country) Maryland					12. CITIZEN OF WHAT COUNTRY? U.S.A.														
13. FATHER'S NAME Thomas Fowler					14. MOTHER'S MAIDEN NAME Madora King					15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No —										16. SOCIAL SECURITY NO. 579-48-9978					17. INFORMANT Address Nettie L. Fowler, Jewell-Dunkirk				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)														
21. I certify that (i) (this hospital) attended the deceased from 8-10-1966 to 1-4-1966, that (ii) (we) last saw the deceased alive on 1/4 1966, and that death occurred at 11 P.M. from the causes and on the date stated above.																													
22a. SIGNATURE Dr. George Weems										M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED 1/4/66														
22c. PHYSICIAN'S NAME (Type) Huntingtown, Md.										22d. ADDRESS																			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF Jan. 7, 1966					23c. NAME OF CEMETERY OR CREMATORY Notre Dame Cemetery					23d. LOCATION (City, town or county) (State) Salem Park, Calvert Md.														
24. FUNERAL DIRECTOR A. A. Harkness & Son										ADDRESS Port Republic, Md.					25a. REC'D BY REGISTRAR JAN 7 1966					25b. REGISTRAR'S SIGNATURE J. Charles Judge									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>									
1. PLACE OF DEATH a. COUNTY Calvert MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Prince Frederick, Md.					c. LENGTH OF STAY IN 1b 1 day				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Calvert County Hospital					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Prince Frederick, Maryland				
					d. STREET ADDRESS 04-1				
3. NAME OF DECEASED (Type or print) Baby Girl Gantt					4. DATE OF DEATH Month 1 Day 15 Year 1966				
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/14/66		9. AGE (In years last birthday) yrs. 16 30	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Calvert County, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles Everett Gantt					14. MOTHER'S MAIDEN NAME Pearl Cureton				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Charles Gantt		Address Prince Frederick, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH	
(b) DUE TO Pneumonia									
(c) DUE TO									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1-15 , 1966 , to 1-17 , 1966 , that (I) (we) last saw the deceased alive on 1-15 , 1966 , and that death occurred at 10:30 M , from the causes and on the date stated above.									
22a. SIGNATURE Dr. Issam F. Damalouji					ATTENDING PHYS. <input checked="" type="checkbox"/> M.D.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/17/66
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS Prince Frederick, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 1-17-66		23c. NAME OF CEMETERY OR CREMATORY Bible Way Church Cem		23d. LOCATION (City, town or county) (State) Prince Frederick-Md			
24. FUNERAL DIRECTOR P. E. Sewell					ADDRESS Prince Frederick-Md.		25a. REC'D BY REGISTRAR 1 JAN 19 1966		25b. REGISTRAR'S SIGNATURE Charles Judge

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Page 9

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00499

1. PLACE OF DEATH a. COUNTY Calvert b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North M. Beach c. LENGTH OF STAY IN 1b 15 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Shenandoah Office				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North M. Beach d. STREET ADDRESS 04-1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Linwood C. German			4. DATE OF DEATH Month 1 Day 13 Year 1966				
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec. 10, 1907		9. AGE (In years last birthday) 58 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Realtor		10b. KIND OF BUSINESS OR INDUSTRY Real Estate	11. BIRTHPLACE (State or foreign country) Sterling, Va.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Linwood R. German			14. MOTHER'S MAIDEN NAME Clara V. Beall				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 577-14-0291	17. INFORMANT Mrs. Vera Wright Address 1520 Chillum Road Hyattsville, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive spontaneous intra-cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Werner U. Spatz		M.D. Werner U. Spatz, M.D.		22. DATE SIGNED 1/14/66			
EXAMINER'S NAME (Type) Werner U. Spatz, M.D.		Address (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Jan. 17, 1966	23c. NAME OF CEMETERY OR CREMATORY Mt. Harmony Chr. Cemetery		23d. LOCATION (City, town or county) (State) Owings, Maryland			
24. FUNERAL DIRECTOR Hutchins Funeral Home		ADDRESS Owings, Maryland		25a. REC'D BY REGISTRAR JAN 19 1966	25b. REGISTRAR'S SIGNATURE Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00509											
Item #4 Film #0372 1/24/66											
00500											
1. PLACE OF DEATH a. COUNTY Calvert b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Prince Frederick c. LENGTH OF STAY IN ID 19 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Calvert County Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chesapeake Beach, Maryland d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Baby Girl Harris			4. DATE OF DEATH Jan 5 19 66			5. SEX Female			6. COLOR OR RACE Colored		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 12/19/65			9. AGE (In years last birthday) 19			10. IF UNDER 1 YEAR Months 19 Days 19 Hours 19 Min. 19		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Calvert County, Md.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.						13. FATHER'S NAME Raymond Harris					
14. MOTHER'S MAIDEN NAME Lucy Viola Jones						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					
16. SOCIAL SECURITY NO.						17. INFORMANT Mrs. Lucy Gorman					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity - Maternal (28 weeks) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 7725 (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>						20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					
20f. (City or town) (County) (State)						21. I certify that (I) (this hospital) attended the deceased from 12-19, 19 65, to 1-5, 19 66 , that (I) (we) last saw the deceased alive on 1/5 19 66 , and that death occurred at 11:00 M, from the causes and on the date stated above.					
22a. SIGNATURE R. E. Seville						22b. DATE SIGNED JAN 10 1966					
22c. PHYSICIAN'S NAME (Type) R. E. Seville						22d. ADDRESS Prince Frederick - Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) 1/6/66						23b. DATE THEREOF 1/6/66					
23c. NAME OF CEMETERY OR CREMATORY Carrolls Church Cem						23d. LOCATION (City, town or county) (State) Barstow Cal. Md.					
24. FUNERAL DIRECTOR P. E. Seville						25a. REC'D BY REGISTRAR JAN 10 1966					
25b. REGISTRAR'S SIGNATURE J. Charles Judge						25c. REGISTRAR'S NAME J. Charles Judge					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00510

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00501

1. PLACE OF DEATH a. COUNTY Calvert b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick, Md c. LENGTH OF STAY IN 1b 7 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Owings, Maryland d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Priscilla Middle Hurley Last Hurley		4. DATE OF DEATH Month 1 Day 1 Year 19 66	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/4/84
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles Hurley		14. MOTHER'S MAIDEN NAME Sarah Jones	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address Sarah Claggett Owings, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic C.V. disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH 8 days
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 29, 1965 to 1/1, 1966 that (I) (we) last saw the deceased alive on 12/29/65 and that death occurred at 2:47 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Dr. Page Jett		22b. DATE SIGNED 1/1/66	
22c. PHYSICIAN'S NAME (Type) Dr. Page Jett		22d. ADDRESS Prince Frederick, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) 1/4/66		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY St. Edmonds Church Cem		23d. LOCATION (City, town or county) (State) Sunderland	
24. FUNERAL DIRECTOR P.E. Sewell		25a. REC'D BY REGISTRAR JAN 4 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

00501

00501

Robert Jackson
Birmingham, AL

Robert Jackson

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00511

00502

Items 13, 14 Film 3374 2/28/66 mh

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY

Calvert
Prince Frederick
Calvert Co

MARYLAND

b. LENGTH OF STAY IN 1b

2. USUAL RESIDENCE OF DECEASED (Where deceased lived, if institution; Residence before admission)

a. STATE

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM?
YES ☐ NO ☐

3. NAME OF DECEASED
(Type or print)

Baby Boy

First

Last

Jacks

4. DATE OF DEATH

Month

Day

Year

1 12 1966

5. SEX

M

6. COLOR OR RACE

C

7. MARRIED ☐ NEVER MARRIED ☐

8. DATE OF BIRTH

1/12/66

WIDOWED ☐ DIVORCED ☐

9. AGE (In years last birthday)

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

James Jacks Earl Thomas

14. MOTHER'S MAIDEN NAME

Dorothy Thomas Ruth Thelma Jacks

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

James Jacks owings- Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

9330

DUE TO

Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.

(b)

DUE TO

(c)

Born slave but died of exposure within a few minutes. Lead on arrival at the hospital.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (When given in Part I, a)

Mother had made no arrangements for delivery

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒

20a. EXTENSAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 19.)

20c. TIME OF INJURY

Month, Day, Year

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

Hour e.m.

7:58 - 1/12/66

While at work ☐ Not While at work ☒

Home

Crump

Calvert

Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

H W Ward

M.D.

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED

1/12/66

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

1-13-66

22c. NAME OF CEMETERY OR CREMATORY

Mt. Hope Church Cem

22d. LOCATION (City, town, or country)

Sunderland

(State)

Md

23. FUNERAL DIRECTOR

ADDRESS

P. E. Sewell

Prince Frederick-Md.

24a. REC'D BY REGISTRAR

JAN 14 1966

24b. REGISTRAR'S SIGNATURE

Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 100-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

6 - 154727

00503

00511

[Faint, illegible handwriting, possibly a list or notes]

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00512 MEDICAL EXAMINER'S CERTIFICATE OF DEATH					00503				
1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>MD</u> b. COUNTY <u>Cecil</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hamletown</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hamletown</u> 04-1				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					e. STREET ADDRESS <u>None</u>				
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Edward</u> Middle <u>Jones</u> Last					4. DATE OF DEATH <u>1</u> <u>15</u> Day <u>19</u> <u>68</u> Year				
5. SEX <u>M</u>		6. COLOR OF RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/10/92</u> <u>83</u> yrs.		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>La</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clay</u>					14. MOTHER'S MAIDEN NAME <u>Elaine Edwards</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give name dates of service)					16. SOCIAL SECURITY NO. <u>577-48-10</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>7824</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. OUE TO (b) OUE TO (c)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Found dead in bed</u>									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Hour <u>4:30</u> a.m. Month <u>11</u> Day <u>15</u> Year <u>68</u>			20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Hamletown</u> (County) <u>Cecil</u> (State) <u>MD</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>H.W. Ward</u>					22. DATE SIGNED <u>11/15/68</u>				
EXAMINER'S NAME (Type) <u>H.W. Ward</u>					M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Bladensburg, Maryland</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-17-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Bladensburg, Maryland</u>			
24. FUNERAL DIRECTOR <u>W.W. Chambers & Son</u> ADDRESS <u>517-11th St. S.E.</u>					25a. REC'D BY REGISTRAR <u>11/17/68</u>		25b. REGISTRAR'S SIGNATURE <u>James Judge</u>		

00203

00210

THE UNIVERSITY OF CHICAGO
LIBRARY

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00513 CERTIFICATE OF DEATH 00504											
1. PLACE OF DEATH a. COUNTY <u>Calvert</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pr. Fred.</u> c. LENGTH OF STAY IN 1b <u>3 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Calvert Nursing Home</u>					2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>ST. MARY'S</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown 18-2</u> d. STREET ADDRESS <u>McKays Beach</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last <u>EDWARD F. KOEGEL</u>			4. DATE OF DEATH Month Day Year <u>Jan 9 1966</u>								
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 4, 1893</u>		9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sub. Public Work</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Brooklyn N.Y.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>? ?</u>					14. MOTHER'S MAIDEN NAME <u>? ?</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes give war or dates of service) <u>WW1</u>			16. SOCIAL SECURITY NO. <u>518-07-9152</u>		17. INFORMANT <u>JOHN O. KOEGEL</u>			Address <u>SAME AS # 2 ABOVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO (b) <u>Arteriosclerosis of the C.V. system</u> DUE TO (c) <u>4221</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> <u>4 years?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>MARCH</u> , 19 <u>63</u> to <u>JAN</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Jan 9</u> , 19 <u>66</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Page C. Jett</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>JAN. 9, 1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>PAGE C. JETT</u>						22d. ADDRESS <u>Shumaker Church, Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>JAN. 12, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST. GEORGE EPISCOPAL</u>			23d. LOCATION (City, town or county) (State) <u>VALLEY LEE, MARYLAND</u>			
24. FUNERAL DIRECTOR <u>W. CLARKE MATTINGLEY</u>						ADDRESS <u>LEONARDTOWN, MARYLAND</u>		25a. REC'D BY REGISTRAR <u>JAN 13 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

20200

LAURENCE, T. J. 1993. *YOUTH IN THE LAKES*.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00514					00505				
1. PLACE OF DEATH a. COUNTY <u>Calvert</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick, Md.</u> c. LENGTH OF STAY IN 1b <u>1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Calvert County Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings, Maryland</u> d. STREET ADDRESS <u>04-1</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Loretta</u> Middle <u>Esmarila</u> Last <u>Marquess</u>			4. DATE OF DEATH Month <u>1</u> Day <u>5</u> Year <u>1966</u>		9. AGE (In years last birthday) <u>68</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/24/97</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>William Cochran</u>				14. MOTHER'S MAIDEN NAME <u>Cassie Ann Stinnett</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Patient</u> Address <u>Owings, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 260X Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (b) <u>Coronary Insufficiency</u> DUE TO (c) <u>Diabetes</u> INTERVAL BETWEEN ONSET AND DEATH <u>16 hrs.</u> <u>2 wks.</u> <u>Several Yrs.</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>1952</u> , 19 <u> </u> to <u>1-5-66</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>1-5-66</u> , 19 <u> </u> , and that death occurred at <u>8:50 AM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Dr. Page C. Jett</u> 22c. PHYSICIAN'S NAME (Type) <u>Dr. Page C. Jett</u> 22b. DATE SIGNED <u>1/7/66</u> 22d. ADDRESS <u>Prince Frederick, Maryland</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Jan 8, 1966</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Mt Harmony Ch. Cem</u> 23d. LOCATION (City, town or county) (State) <u>Owings Md</u>									
24. FUNERAL DIRECTOR <u>Hutchins Funeral Home (Owings, Md.)</u> 25a. REC'D BY REGISTRAR <u>JAN 12 1966</u> 25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00515					00506						
1. PLACE OF DEATH a. COUNTY Calvert b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) prince frederick c. LENGTH OF STAY IN 1b 6 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Calvert county Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) North Beach d. STREET ADDRESS 04-1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Nellie First Augusta Middle Neuhaus Last			4. DATE OF DEATH 1 Month 24 Day 19 66 Year								
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/8/96		9. AGE (In years last birthday) 69 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		IF UNDER 1 YEAR Months Oays Hours Min.			
13. FATHER'S NAME John P. Taylor				14. MOTHER'S MAIDEN NAME Catherine C. Taylor							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT John F. Lanham Address 2505 Afton St., Hillcrest Heights, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 022X Aortic aneurysm DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thoracic; cause unknown DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 8/1/66 , to 1/24/66 , that (I) (we) last saw the deceased alive on 1/23/66 , and that death occurred at 6:20 M, from the causes and on the date stated above.											
22a. SIGNATURE George J. Weems M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22b. DATE SIGNED 1/24/66					
22c. PHYSICIAN'S NAME (Type) George J. Weems, M. D.						22d. ADDRESS Huntingtown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 26th-66		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town or county) (State) Suitland, Maryland					
24. FUNERAL DIRECTOR Simmons Bros. ADDRESS 1661- Good Hope Rd. SE. Wash., DC						25a. REC'D BY REGISTRAR JAN 26 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00516

00507

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. LENGTH OF STAY IN 1b <u>17</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Calvert County Hospital</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Port Republic</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Susie Elizabeth Rice</u>				4. DATE OF DEATH Month Day Year <u>Jan. 10 19 66</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-22-07</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Calvert County, Md</u>	
13. FATHER'S NAME <u>William Golder</u>				14. MOTHER'S MAIDEN NAME <u>Roberta Brady</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>John T. Rice</u>		Address <u>Port Republic, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malignant tumor due to</u> <u>2001</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Lymphosarcoma in abdomen wall</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>year</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov</u> , 19 <u>65</u> , to <u>1/10</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1/10</u> , 19 <u>66</u> , and that death occurred at <u>9:30</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>R. E. SWEET</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS <u>Port Republic, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>1-15-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Brooks Church Cem</u>		23d. LOCATION (City, town or county) (State) <u>Mutual Md</u>	
24. FUNERAL DIRECTOR <u>P. E. SWEET</u>				ADDRESS <u>Prince Frederick, Md</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
				25b. REGISTRAR'S SIGNATURE			

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item #9 Film #G373 2/11/66 pc

00508

1
FOR STATE
HEALTH DEPT.

PLACE OF DEATH
a. COUNTY

Calvert

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Huntingtown, Md.

c. LENGTH OF STAY IN 1b

8 YEARS

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)

a. STATE Maryland

b. COUNTY Calvert

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Neeld's Estate, Huntingtown, Md.

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM?
YES ☐ NO ☒

3. NAME OF DECEASED
(Type or print)

First Marguerite

Middle Marie

Last Riordon

4. DATE OF DEATH

Month 1

Day 29

Year 19 66

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

12/07/97

9. AGE (In years last birthday) yrs. 68 69

IF UNDER 1 YEAR Months Days

IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Own home

11. BIRTHPLACE (State or foreign country)

Riverdale, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Harry Thornton Knight

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

None

YES

17. INFORMANT

Joseph R. Riordon

Address 1302 Geranium Street, N. W. Washington, D. C.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

FATTY INFILTRATION OF LIVER

5810

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?
YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19

20d. INJURY OCCURRED While ☐ at work Not While ☐ at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☒

M.D. ASSISTANT MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL SIGNATURE

R.S. Fisher

EXAMINER'S NAME (Type)

R.S. FISHER

DEPUTY MEDICAL EXAMINER ☐
BALT. MORE, MD
Address (Street, city, town, or county)

1/30/66

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

2-3-66

22c. NAME OF CEMETERY OR CREMATORY

Cedar Hill Cemetery

22d. LOCATION (City, town, or country)

Suitland, Maryland

23. FUNERAL DIRECTOR

Warner E. Pumphrey, Inc.

ADDRESS

8434 Georgia Avenue Silver Spring, Md.

24a. REC'D BY REGISTRAR

FEB 7 1966

24b. REGISTRAR'S SIGNATURE

Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00518 CERTIFICATE OF DEATH 00509

1. PLACE OF DEATH a. COUNTY Calvert b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN b 2 1/2 yr. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert Nursing Home, Prince Frederick, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Pr. Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wash. D.C. 16-2 d. STREET ADDRESS 314 Carmody Hills Dr		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Rachel Middle C Last Simmons		4. DATE OF DEATH Month Jan. Day 18 Year 1966			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 27, 1918	9. AGE (In years last birthday) 47 yrs.	IF UNDER 1 YEAR Months 8 Days 27 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania	
13. FATHER'S NAME William Winter		12. CITIZEN OF WHAT COUNTRY? U S A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578.30,8360		17. INFORMANT A. Roberta C. Myers	
		Address 314 Carmody Hills Dr			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 493X DUE TO (b) Cardiac Failure DUE TO (c) 					INTERVAL BETWEEN ONSET AND DEATH 48 hours 24 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1963 , 19 , to 1-18 , 1966 , that (I) (we) last saw the deceased alive on Jan. 18 , 1966 , and that death occurred at 10 a.m., from the causes and on the date stated above.					
22a. SIGNATURE Page C. Jett				22b. DATE SIGNED 1-18-66	
22c. PHYSICIAN'S NAME (Type) Page C. Jett				22d. ADDRESS Prince Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1.21.66		23c. NAME OF CEMETERY OR CREMATORY Pike Brethren Ch. Cem	
				23d. LOCATION (City, town or county) (State) Mundys Corner Penna	
24. FUNERAL DIRECTOR Lee Funeral Home 300.4th st N E				25a. REC'D BY REGISTRAR IAN 21 1966	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

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[Handwritten signature]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00519

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Samantha Middle Smith Last				4. DATE OF DEATH Month Jan. Day 15 Year 1966			
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/2/65		9. AGE (In years last birthday) yrs. 11 Months 11 Days 14	IF UNDER 1 YEAR Hours 11 Min. 14	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Sherman Smith				14. MOTHER'S MAIDEN NAME Mable Watkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Sherman Smith Owings, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exposure 9320 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Extreme cold weather, baby became uncovered DUE TO (c) uncovered</p> </div> <div style="width: 15%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE				DATE SIGNED			
EXAMINER'S NAME (Type) G. J. Weems, M. D.				1/15/66			
				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
		1/17/66		Mt. Hope Cem.		Calvert Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Pinkney E. Sewell				ADDRESS Prince Frederick, Md.		24a. REC'D BY REGISTRAR JAN 18 1966	
				24b. REGISTRAR'S SIGNATURE 			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

5-167651

WESTLAND STATE DEPARTMENT OF HEALTH - BATHING IS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00510

0051

NAME OF DECEASED		SEX		AGE		DATE OF DEATH	
LAST NAME		FIRST NAME		MIDDLE NAME		DATE	
STREET ADDRESS		CITY		COUNTY		STATE	
HOME PHONE		BUSINESS PHONE		HOSPITAL		DOCTOR	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION	
PREVIOUS ILLNESS		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
SIGNATURE OF EXAMINER		DATE		TIME		HOURS	
OFFICE OF THE EXAMINER		ADDRESS		CITY		STATE	
TELEPHONE		FAX		E-MAIL		WEBSITE	
FEE		TAXES		TOTAL		PAID	
REMARKS		FINDINGS		TREATMENT		DISPOSITION	
SIGNATURE OF WITNESS		DATE		TIME		HOURS	
OFFICE OF THE WITNESS		ADDRESS		CITY		STATE	
TELEPHONE		FAX		E-MAIL		WEBSITE	
FEE		TAXES		TOTAL		PAID	
REMARKS		FINDINGS		TREATMENT		DISPOSITION	

00510

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00520 MEDICAL EXAMINER'S CERTIFICATE OF DEATH					00511				
1. PLACE OF DEATH a. COUNTY Calvert b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert Co. Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Benedict d. STREET ADDRESS 08-2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Charles B. Tippet			4. DATE OF DEATH Month 1 Day 10 Year 1966						
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Jan. 23 1906		9. AGE (In years last birthday) 59 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bar tender			10b. KIND OF BUSINESS OR INDUSTRY Restaurant			11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Neale Tippet			14. MOTHER'S MAIDEN NAME Essie Burroughs						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. 216-10-6038		17. INFORMANT Mrs. Essie Tippet-Benedict, Md. Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushing of chest with traumatic rupture of aorta 8164 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) driver in auto-auto collision						
20c. TIME OF INJURY Month, Day, Year Hour 8:15 p.m. 1 10 19 66			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street		20f. (City or town) Benedict (County) Charles (State) Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Werner U. Spitz			M.D. Werner U. Spitz, M.D.		22. DATE SIGNED 1/11/66				
EXAMINER'S NAME (Type)			Address (Street, city, town, or county)						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 1-13-66		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cem.		23d. LOCATION (City, town or county) (State) Bryantown, Md.		
24. FUNERAL DIRECTOR Hunt Funeral Home, Waldorf, Md.			ADDRESS		25a. REC'D BY REGISTRAR Jan 14 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

00511

00550

X 201 23 1956

Postmaster: Restaurant, Maryland
Charles M. Tippett, Esq.
1200

at 1-15
... ..

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00521						00512					
1. PLACE OF DEATH a. COUNTY						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Prine Frederick</i>						b. COUNTY <i>Maryland</i>					
c. LENGTH OF STAY IN 1b						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Chas. Fiske Beach 04-1</i>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Cabnet County Hospital</i>						d. STREET ADDRESS <i>—</i>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <i>Lillian White Tyler</i>						4. DATE OF DEATH Month <i>Jan.</i> Day <i>21</i> Year <i>1966</i>					
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Jan. 23, 1885</i>		9. AGE (in years last birthday) <i>80 yrs.</i>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>				11. BIRTHPLACE (County & State, or foreign country) <i>South Dakota</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Unknown</i>						14. MOTHER'S MAIDEN NAME <i>Unknown</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>P</i>		17. INFORMANT <i>Mrs. Gladys Paddy - Huntington, Ind</i>				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Failure</i> <i>0969</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Technical glaucoma</i> (c) <i>Viral infection</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Older than question & answer</i>										INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>1945</i> , 19 <i>66</i> to <i>1/21</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>1/20</i> , 19 <i>66</i> , and that death occurred <i>1/21</i> , 19 <i>66</i> , from the causes and on the date stated above.											
22a. SIGNATURE <i>H. W. Ward</i>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>1/21/66</i>			
22c. PHYSICIAN'S NAME (Type) <i>H. W. WARD</i>						22d. ADDRESS <i>Cornup</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>Jan. 24, 1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Wesley Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Prine Frederick, Ind.</i>			
24. FUNERAL DIRECTOR <i>B. A. Warkunas & Son</i>						ADDRESS <i>Munich Bldg 34</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
						DATE <i>JAN 25 1966</i>					

00518

00521

[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. File 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2 1 (M)
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00513

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Calvert</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Crump</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <i>04-1</i>	
3. NAME OF DECEASED (Type or print) First <i>Edward</i> Middle <i>J.</i> Last <i>Watkins</i>		4. DATE OF DEATH Month <i>1</i> Day <i>31</i> Year <i>1966</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 13</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labor</i>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>51</i> yrs. IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Walter Sollars</i>		14. MOTHER'S MAIDEN NAME <i>Bertie Brown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>212-14-7502</i>	
17. INFORMANT <i>Dorothy Watkins - Owings</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>3222</i> DUE TO <i>Alcohol & Exposure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Had been drinking at home</i>	
20c. TIME OF INJURY Month, Day, Year <i>10/31/66</i> Hour a.m. <i>11:31</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <i>at home</i>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) <i>Crump</i> (County) <i>Calvert</i> (State) <i>MD</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <i>A W Ward</i> M.D.		22. DATE SIGNED <i>1/31/66</i>	
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)		23a. BURIAL, CREMATION, REMOVAL (Specify)	
23b. DATE THEREOF <i>2-5-66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Moses</i>	
23d. LOCATION (City, town or county) (State) <i>AA. Co. Md</i>		24. FUNERAL DIRECTOR <i>Prince Frederick-Md.</i>	
25a. REC'D BY REGISTRAR <i>FEB 4 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

00518

00523

RECEIVED

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00523

00514

1. PLACE OF DEATH o. COUNTY Calvert MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings				c. LENGTH OF STAY IN 1b 4 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Padgett's Nursing Home				d. STREET ADDRESS 02-2			
3. NAME OF DECEASED (Type or print) First Rose Middle Edna Last Wood				4. DATE OF DEATH Month January Day 16 Year 1966			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 2, 1889	
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months 76 Days 0 Hours 0 Min. 0		11. IF UNDER 24 HRS. Hours 0 Min. 0		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress				10b. KIND OF BUSINESS OR INDUSTRY Clothing		11. BIRTHPLACE (State or foreign country) Friendship, Maryland	
13. FATHER'S NAME John S. Wood				14. MOTHER'S MAIDEN NAME Rosie A. Ward			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mr. James Wood Address Friendship, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic jejune carcinoma - 1992 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause lost. (c) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 31 19 56 , to Jan 16 19 66 , that (I) (we) last saw the deceased alive on Jan 15 19 66 , and that death occurred at 9 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Emily H. Wilson				22b. ADDRESS Lothian, Maryland		22c. DATE SIGNED 1-17-66	
22c. PHYSICIAN'S NAME (Type) Emily H. Wilson				22d. ADDRESS Lothian, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 19, 1966		23c. NAME OF CEMETERY OR CREMATORY Friendship Chr. Cemetery		23d. LOCATION (City, town, or county) (State) Friendship, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Hutchins Funeral Home				25a. REC'D BY REGISTRAR Jan 19 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director.

00530

COMMUNIST IN TRANS

00530